



**KENTUCKY BOARD OF
EMERGENCY MEDICAL SERVICES**

COMMONWEALTH OF KENTUCKY
2545 LAWRENCEBURG ROAD
FRANKFORT, KENTUCKY 40601
PHONE: 502-564-8963
FAX: 502-564-4687



AFFIDAVIT OF EDUCATIONAL INSTITUTION REPRESENTATIVE

I affirm that the information contained in this application is accurate and complete to the best of my knowledge. I understand that incomplete, inaccurate or false information may result in failure to have the training course approved, withdrawal of approval of the training course, and/or failure of students enrolled in the training course to act as trainees, graduate, or to become licensed/certified pursuant to current regulations.

I further understand that the Kentucky Board of Emergency Medical Services or its representative may inspect the training course during the conduct of the class to determine the quality of the class and the adherence of the education institution to the applicable statutes and administrative regulations.

Signature of Designated Representative of the Educational Institution

Date

Signature of Course Coordinator

Date

Signature of Medical Director

Date

Subscribed and sworn before me by _____

this _____ day of _____, 200__.

Notary Public

My Commission Expires _____

KBEMS- 04/2004